TILLMAN PHYSICAL THERAPY & SPORTS TRAINING CENTER

Cedar Park
2519 S Lakeline Blvd
Ste 100
Cedar Park, TX 78613
(512) 331-6200
Fax (512) 331-6384

Four Points
11007 FM 2222
Austin, TX 78730
(512) 792-4041
Fax (512) 532-6701

Patient Demographic Sheet

Please use Black ink only & print clearly

Referred by: _____

Last Name: _____ First Name: _____

Mailing Address: _____ Apt/Ste: _____

City: _____ State: _____ Zip: _____

Gender: _____Marital Status: _____

Employer: _____ Occupation: _____

Phone (Home):_____ (Work) _____ (Cell) _____

Date of Birth: _____ SSN: _____ Driver's License #:_____

Emergency Contact: 1) Name _____ Phone _____ Relationship _____

2) Name _____ Phone _____ Relationship _____

Primary Insurance: Insurance Co: _____ Policy ID #: _____

Group#: _____ Policy Holder Name: _____

Date of Birth: _____ SSN: _____ Employer: _____

Address (if different from Pt): _____

City _____ State: _____ Zip: _____Relationship to Pt: _____

Secondary Insurance: Are you covered by a secondary insurance? YES / NO

Insurance Co: _____ Policy ID #: _____

Group#: _____ Policy Holder Name: _____

Date of Birth: _____ SSN: _____ Employer: _____

Address (if different from Pt): _____

City _____ State: _____ Zip: _____Relationship to Pt: _____

Patient Name: _____ Date of Birth: _____

- I hereby give authorization for payment of medical and/or auto insurance benefits and/or legal settlement payments to be made directly to Tillman Physical Therapy & Sports Training Center, Inc., and for any assisting therapist employed by or contracted with Tillman Physical Therapy & Sports Training Center, Inc. only. I hereby authorize Tillman Physical Therapy & Sports Training Center, Inc. to release any and all information necessary to secure payment of benefits to only those parties legally entitled to receive information for purposes of receiving payment of existing balances or for authorization for continuation of services as may be necessary or requested by the patient's insurer(s).

- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance, provided I am notified in advance that any proposed service or therapy/treatment/procedure may not be covered by patient's insurance provider(s).

- **I understand that all copay, coinsurance and deductible amounts are due and payable at the time of service, unless a payment arrangement has been made with the billing office. Tillman Physical Therapy & Sports Training Center, Inc will bill my insurance company or companies. If the explanation of benefits from the insurer(s) shows a remaining patient balance due, the patient will be billed accordingly. In the event of a default in payment, the prevailing party in any lawsuit or mediation will be entitled to recover reasonable attorney fees and actual costs of collection.**

- 24 hours notice is required if you must cancel or reschedule an appointment so that we may provide another patient with that appointment opportunity. Exceptions are for Monday appointments when 24 hour notice is not possible or when your appointment is the day after a holiday. There is a $25.00 charge for missed appointments that are not cancelled with 24 hours advance notice. (See exception policy above.)

- I agree that a photocopy of this agreement shall be as valid as the original.

Thank you for your cooperation.

Patient (if minor – Parent or Legal Guardian) Signature: _____

Date: _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDEMENT FORM

I, _____, have received a
Patient Name

copy of Tillman Physical Therapy & Sports Training Center, Inc. Notice of Privacy Practices.

_____ _____
Signature of Patient Date

Tillman Physical Therapy & Sports Training Center, Inc. was unable to obtain acknowledgement because:

- ❑ Emergency
- ❑ Patient Non-Responsive
- ❑ Patient Sedated
- ❑ Patient Confused/Disoriented
- ❑ Patient Refused – Reason _____
- ❑ Other _____

_____ _____
Staff Signature Date

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Patient Medical History

Name: _____ Referring Physician: _____ Primary Physician: _____
Current Height: _____ Weight: _____
Are you currently taking any prescription or non-prescription medications? Yes/No

Please list all medications: _____
_____

Have you had any of the following Medical or Rehabilitative Service for this Injury/Episode? (circle one)

Chiropractor	Yes	No	CT Scan	Yes	No
EMG/NCV	Yes	No	General Practitioner	Yes	No
Massage Therapy	Yes	No	MRI	Yes	No
Myelogram	Yes	No	Neurologist	Yes	No
Occupational Therapist	Yes	No	Orthopedist	Yes	No
Physical Therapist	Yes	No	Podiatrist	Yes	No
Emergency Room	Yes	No	X-Rays	Yes	No

Other: _____

General Health Information: Do you know or have you had ANY of the following? Circle all that apply.

Asthma, Bronchitis, or Emphysema	Yes	No	Severe or Frequent Headaches	Yes	No
Shortness of Breath/Chest Pain	Yes	No	Vision or Hearing Difficulties	Yes	No
Coronary Heart Disease or Angina	Yes	No	Numbness or Tingling	Yes	No
Pacemaker	Yes	No	Dizziness or Fainting	Yes	No
High Blood Pressure	Yes	No	Ringing in ears	Yes	No
Heart Attack or Surgery	Yes	No	Weakness	Yes	No
Stroke/TIA	Yes	No	Weight Loss/Energy Loss	Yes	No
Blood Clot/Emboli	Yes	No	Hernia	Yes	No
Epilepsy/Seizures	Yes	No	Tuberculosis	Yes	No
Thyroid Trouble/Goiter	Yes	No	Allergies	Yes	No
Anemia	Yes	No	Any pins or metal implants	Yes	No
Infectious Disease	Yes	No	Joint Replacement	Yes	No
Diabetes	Yes	No	Neck injury/surgery	Yes	No
Cancer or Chemotherapy/Radiation	Yes	No	Shoulder injury/surgery	Yes	No
Arthritis/Swollen Joints	Yes	No	Elbow/Hand injury/surgery	Yes	No
Osteoporosis	Yes	No	Back injury/surgery	Yes	No
Gout	Yes	No	Knee injury/surgery	Yes	No
Sleeping problems/difficulties	Yes	No	Leg/Ankle/Foot injury/surgery	Yes	No
Emotional/Psychological Problems	Yes	No	Are you Pregnant	Yes	No
Bowel or Bladder Problems	Yes	No	Do you Smoke	Yes	No

List any other information that would assist us in your care: _____
_____
Are you aware of your diagnosis? Yes/No
Based upon your awareness, what are your expectations/goals in this program? _____
_____

Patient/Guardian Signature: _____ Date: _____

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Patient Health/Injury Questionnaire

Patient Name: _____ **Date of birth:** _____

Circle the appropriate answer for each of the following questions:

Patient Type	New	Established, new injury	Established, new episode	Established, continuing care

Nature of Condition	Initial onset (within last 3 months)	Recurrent (multiple episodes of < 3months)	Chronic (continuous duration > 3months)

Cause of Current Episode	Traumatic	Unspecified	Repetitive	Post - Surgical (see below)	Work Related	Motor Vehicle

For post-surgical patients - Date of Surgery: _____

Surgery Type	ACL Reconstruction	Rotator Cuff/Labral Repair	Tendon Repair	Spinal Fusion	Joint Replacement	Other _____ _____

Date symptoms began: _____ **Briefly describe your symptoms:** _____

_____

How did your symptoms start? _____

_____

Average pain intensity (circle one):

Last 24 hours: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

Past week: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

How often do you experience your symptoms?

Constantly (76-100% of the time) Frequently (51-75% of the time) Occasionally (26%-50% of the time)
Intermittently (0%-25% of the time)

How much have your symptoms interfered with your usual daily activities: (including both work outside the home and housework)

Not at all A little bit Moderately Quite a bit Extremely

How is your condition changing, since care began at this facility"

N/A - this is the initial visit Much worse Worse A little worse No change A little better Better Much better

In general, would you say your overall health right now is...

Excellent Very good Good Fair Poor

Patient Signature: X_____Date:_____